Children's Special Health Services
Client Registration

Client Information

Full Name_____ DOB_____ Sex____ Ethnicity_____ Race_____

SSN_____ Address _____City_____ Zip Code _____

Phone #_____ Additional Demographic Information_____

Parent/Guardian Information

Full Name_____ DOB_____ Sex____ Ethnicity_____ Race_____

SSN_____ Address _____City_____ Zip Code _____

Phone #_____ Additional Demographic Information_____

Medical Information

Presenting Diagnosis/Problem _____

Doctor's Full Name_____ Address_____ City_____

Insurance/Medicaid Information

Insurance Company_____ Group Plan Employer_____

Insurance Address_____ City_____ State_____ Zip Code_____

Policy Holder_____ Relationship to Client_____ Policy #_____

Group #_____ Deductible_____ Co-Payment_____ Start Date _____

Rider in Place_____ Referral Required_____ Authorization #_____

Primary Insurance Policy Holder

Full Name_____DOB_____Sex_____SSN_____

Address _____City_____ Zip Code _____ Phone #_____

Request for Financial Assistance

Applying for financial assistance? _____ (yes or no)